DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 5

2. STATE: MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
4-1-2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.25(6)

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ -0-
b. FFY 2001 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pp 4-~~27~~ 32, ~~Appendix A~~
5/18/01 Per N. Bishop FRAH

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pp 4-26, Appendix A

10. SUBJECT OF AMENDMENT:
Updates DRG hospital prices, Per Diem rates and DRG grouper

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
James K. Haveman, Jr.

14. TITLE:
Director

15. DATE SUBMITTED:
6-26-00

16. RETURN TO:
Michigan Department of Community Health
Office of Federal Liaison
Lewis Cass Building, 6th Floor
320 South Walnut Street
Lansing, Michigan 48913
ATTN: N. Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
6/30/00

18. DATE APPROVED:
6/6/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
4-1-00

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
JUN 30 2000
DMIO - MIM...

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS OF PAYMENT OF REASONABLE COSTS -
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(Relative Weight x DRG Price) + Outlier Payment

Each inpatient hospital claim is assigned to a DRG using the same DRG grouper version used to establish the relative weights.

A. Relative Weight:

A statewide relative weight is assigned to each DRG. The statewide relative weights are calculated using Medicaid and Children's Special Health Care Services Program inpatient claims for admissions between October 1, 1993 and September 30, 1995 paid by June 30, 1997; and hospital specific cost report data drawn from cost report years ending between October 1, 1994 and September 30, 1995.

The claim file was adjusted to:

- Combine multiple billings for the same episode of service, including:
  - Invoices from a single episode of service billed as a transfer from a hospital and an admission to the same hospital caused by a change of ownership and issuance of a new Medicaid ID number,
  - Invoices for a single episode of service billed as a transfer from a hospital and an admission to a hospital created from a merger of two or more hospitals and the assignment of patient bills from multiple hospitals to a single Medicaid ID number.
- Eliminate episodes with any Medicare charges;
- Eliminate episodes assigned to DRGs reimbursed by multiplying a hospital's inpatient operating cost to charge ratio by charges;
- Eliminate episodes without any charges or days;
- Assign alternate weights for neonatal services. Two sets of weights are calculated for six (6) DRG classifications representing neonatal services (385-390). One set of weights is identified as "alternate weights" (385.1, 386.1, 387.1, 388.1, 389.1 and 390.1). These alternate weights are calculated from episodes that are assigned to one of these DRGs and include charges for services in an intensive care unit of one of the hospitals designated as having a neonatal intensive care unit (NICU). The remaining claims assigned to these DRGs are used for the other set of weights.

  In order to receive the alternate weights, a hospital must have a Certificate of Need (CON) to operate a NICU or a special newborn nursery unit (SNNU) or the hospital must have previously received alternate weight reimbursement by Medicaid for its SNNU.
- Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data are available for a period ending between October 1, 1994 and September 30, 1995);

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- Limit episodes to those with a valid discharge status (incomplete episodes are excluded as are additional pages of multiple page claims where there is no initial claim containg a valid discharge status);

- Determine the 3rd and 97th percentile length of stays by DRG, the average length of stay, and the maximum length of stay.

  - Set the low day outlier threshold at the greater of one day or the 3rd percentile length of stay.

  - Set the high day outlier threshold at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay.

  - If the DRG has less that an adequate number of episodes (currently 32), the low day threshold will be set at the lesser of the average length of stay plus 30 days, the maximum length of stay, or the Medicare DRG 90th percentile length of stay (from the corresponding Grouper as published in the Federal Register). If the Medicare DRG also has an inadequate number of claims, then the threshold is set based upon the expert advice of the MSA's medical staff.

- Eliminate low day outliers (Low day outliers are those episodes whose length of stay are less than the published low day threshold for each DRG. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio times charges, and do not receive a DRG payment, they are excluded from the weight calculations);

- Calculate the arithmetic mean length of stay for each DRG with each episode's length of stay limited to the high day threshold set above. This serves as the final published average length of stay.

- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (for DRGs 385 and 385.1 all transfers are included);

- Bring all charges for admissions in the first year of the base period up to second year charges through application of an inflation factor derived from the 1st Quarter 1997 Data Resources, Inc., PPS Hospital Market Basket Index,

- Recognize hospital specific cost differences by dividing the charges for each hospital by a hospital specific cost adjustor factor. Each hospital's cost adjustor is calculated as follows:

  - Cost Adjustor = 0.9 x Wage Adjustor + 0.1

  - This formula is the algebraic deviation of:

    - 0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

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The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.

- Each hospital's wage factor is wage per F.T.E. divided by the statewide average hospital wage per F.T.E. Medicare audited wage data for hospital fiscal years ending between Ocotber 1, 1996 and September 30, 1997 is used. Contract labor cost is included in determining a hospital's wage costs.

- Each hospital's wage costs are adjusted for different fiscal year ends by multiplying the hospital's wage costs by inflation factors. All wages are brought to a common point in time.

  For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the fiscal year ends is used.

- If two or more hospitals merged and are now operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data will be inflated to a common point in time.

- Indirect medical education (IME) charges are removed by dividing each hospital's adjusted charges by an IME adjustor. Each hospital's IME adjustor is calculated as follows:

$$1+([(1+\frac{Interns\ \&\ Residents}{Beds})^{.5795}-1]\times 0.715)$$

  - The number of beds for each hospital is the average number of available beds for the hospital. Available licensed beds are limited to beds in the medical/surgical portion of the hospital. Interns and residents are only those allocated to the medical/surgical portion of the hospital.

  - If two or more hospitals merge and are operating as a single hospital, IME data is computed after the merger using the combined cost report data from all hospitals involved in the merger.

- Adjust charges for high day and/or cost outliers to approximate the charges for the non-outlier portion of the stay.

  - If a claim's length of stay is greater than the high day outlier threshold for the DRG, then it is considered a high day outlier claim. Adjusted charges representing an estimate of the non-outlier portion of charges for high day outliers are used for the relative weight and price calculations as follows:

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$$Adj\ Chrg = \frac{Charges \times High\ Day\ Threshold}{High\ Day\ Threshold + [.6 \times (LOS - High\ Day\ Threshold)]}$$

- A claim is a cost outlier if its costs (i.e. charges times hospital's inpatient operating cost to charge ratio) are greater than the cost threshold for that DRG (the threshold is set at the larger of twice the DRG payment or $50,000).
  - The cost to charge ratio is each hospital's inpatient operating cost to charge ratio, not to exceed 1.0.
  - The adjusted charges for cost outliers use a cost threshold estimate the greater of:

    Cost Threshold = 2 x Avg. Cost for DRG

    Or $50,000.

  - Adjusted charges are calculated as follows:

$$Adj\ Chrg = Charges - \frac{[(Charges \times Cost\ Ratio) - Cost\ Threshold] \times 0.85}{Cost\ Ratio}$$

  - If an episode is both a high day and a cost outlier, the lesser of the two adjusted charges is used in computing the relative weights and DRG prices.

- The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost to charge ratio.
  - Each hospital's Title XIX operating cost to total charge ratio is obtained from filed cost report for fiscal years ending in the second year of the base period. If the cost to charge ratio is greater than 1.0, then 1.0 is used.
  - If two or more hospitals merge, and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data will be inflated to a common point in time.
- The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG.
- The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG is included in Appendix A.

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- Bring all charges for discharges between October 1, 1993 and September 30 1994 to the period of October 1, 1994 through September 30, 1995 through application of an inflation factor of 1.027.

Data for current wage adjustors are taken from hospital cost reporting periods ending between October 1, 1994 and September 30, 1995. Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation factors. All wages are brought to a common point in time. The following adjustment factors derived from the first quarter 1997 Data Resources, Inc. PPS-Type Hospital Market Basket Index, employee cost component, are used:

FYE	Wage and Benefit Inflation to 94/95
12/31/94	1.019
3/31/95	1.012
6/30/95	1.006
9/30/95	1.000

For hospitals with cost reporting periods ending other than at the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

B. DRG Price:

The episode file as adjusted is used for DRG price calculations with the following exceptions:

- The episode file is limited to those hospitals enrolled as of October 1, 1993.
- The episode file is limited to claims from admissions during each hospital's fiscal year ending during the second year of the base period.
- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The adjusted cost for each hospital is summed.
- The hospital specific base price (cost per discharge for a case mix of 1.00) is computed.
  - ➢ Divide total adjusted cost by total number of episodes.
  - ➢ Divide average costs by the case mix.
  - ➢ Multiply the result by the applicable inflation factor. Costs are inflated through the rate period. Inflation factors are obtained from the Data Resources, Inc. PPS -Type Hospital Market Basket Index.

5. Cost per discharge (line 3/line 4).
6. Hospital's casemix.
7. Inflation.
8. Hospital's base price (line 5 * line 7/line 6).
9. Establish the statewide base limit (mean plus one standard deviation).
10. Hospital's limited base price (lesser of lines 8 or 9).
11. Establish the statewide operating cost limit (truncated, weighted mean of line 10).
12. Hospital's DRG base price (lesser of lines 8 or 11).
13. Calculate the hospital's incentive is applied (if line 12 < line 11, 10% of line 12 - line 11, otherwise 0).
14. Hospital's DRG base price plus any incentive (line 12 plus line 13).
15. Hospital's Cost Adjustor.
16. Hospital's final DRG price (line 14 x line 15). The DRG price is rounded to the nearest whole dollar amount.

C. Special Circumstances Under DRG Reimbursement

In some special circumstances, reimbursement for operating costs uses a DRG daily rate. The DRG daily rate is:

$$\frac{DRG\ Price \times Relative\ Weight}{Average\ Length\ of\ Stay\ for\ the\ DRG}$$

The average length of stay, low day and the high day outlier thresholds for each DRG are listed in Appendix A at the end of this section.

1. High Day Outliers

High day thresholds are set at the lesser of the 97th percentile of the length of stay or 30 days beyond the mean length of stay for each DRG.

Reimbursement for high day outliers is:

$$DRG\ Price \times Rel.Wt. + [60\% \times Outlier\ Days \times (\frac{DRG\ Price \times Rel.Wt.}{Avg.\ LOS\ for\ the\ DRG})]$$

If an episode is both a high day and a cost outlier, reimbursement will be the greater of the two amounts.

2. Low Day Outliers

For services where the length of stay is less than the published low day threshold, reimbursement is actual charges multiplied by the individual hospital's inpatient operating cost to charge ratio excluding IME, not to exceed the full DRG payment. The specific low day outlier threshold for each DRG is listed in Appendix A.

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3. Less than Acute Care

If a claim is a high day outlier and review shows that the beneficiary required less than acute continuous medical care during the outlier day period, Medicaid will pay for the less than acute care days at the statewide average nursing facility per diem rate for the outlier days, if nursing facility care is medically necessary.

4. Cost Outliers

An episode is a cost outlier when costs for the episode (charges times the hospital's inpatient operating cost to charge ratio excluding IME) exceed the computed cost threshold. Claims assigned to DRGs paid a percent of charge cannot be cost outliers.

Reimbursement for cost outliers will be dependent upon the cost threshold.

The Cost Threshold is the larger of:

- 2 x DRG Price x Rel. Wt. (twice the regular payment for a transfer paid on a per diem basis for episodes getting less than a full DRG), or
- $50,000

Cost Outliers will be reimbursed according to the following formula:

(DRG Price x Rel. Wt.) +(85% x [(Charges x Operating Ratio) - Cost Threshold])

If an episode is both a high day and a cost outlier, reimbursement is the greater of the two amounts.

5. Transfers

Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.

a. Payment to the Transferring Hospital

Except in the cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the beneficiary's stay, not to exceed the appropriate full DRG payment, plus an outlier payment, if appropriate. If the transferring hospital is a specialty hospital (e.g. burn, neonatal), depending on the submitted documentation, and a request for "individual consideration" or the actual number of days of stay, payment may be a full DRG payment, plus an outlier payment as appropriate.

b. Payment to the Receiving Hospital

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If the patient is discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.

Reimbursement is based on discharge in the following situations. If the beneficiary:

- Is formally released from the hospital, or
- Is transferred to home health services, or
- Dies while hospitalized, or
- Leaves the hospital against medical advice, or
- Is transferred to a long-term care facility.

If the patient transferred again, the hospital is paid as a transferring hospital.

6. Readmissions

Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes.

If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.

Readmissions for an unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.

7. Percent of Charge Reimbursement

The payment amount for pancreas transplants (surgical procedures 52.80 through 52.83), and for claims that fall into DRGs 103, 468, 480, 481 or 495 is total hospital charges times the hospital's inpatient operating cost to charge ratio excluding IME.

The ratio is the hospital's Title XIX inpatient operating cost to charge ratio as obtained from filed cost reports for fiscal years ending between October 1, 1994 and September 30, 1995.

8. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide operating cost limit (truncated mean of base prices located in Michigan).

Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year - October 1st through September 30th) may be reimbursed the hospital's inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospitals' chief financial officer must submit and

the MSA must accept documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.

9. New Hospitals

A new medical/surgical hospital is one for which no Michigan Medicaid program cost or paid claims data exists during the period used to establish hospital specific base rates or one which was not enrolled in the Medicaid program when hospital specific base prices/rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

The DRG base price for new general hospitals is the statewide operating limit until new DRG base prices are calculated for all hospitals using data from time periods during which the new hospital provided services to Medicaid beneficiaries.

D. Hospitals and Units Exempt from DRG Reimbursement

1. Calculating Per Diem Rates

The per diem prices calculated for the Michigan Medicaid system utilize Medicaid and Children's Special Health Care Services inpatient claims for admissions from September 1, 1995 through August 31, 1997 paid by June 30, 1999. Hospital specific cost report data is drawn from cost report years ending between September 1, 1996 and August 31, 1997.

The claim file is limited to those hospitals enrolled as of the specified dates and is limited to claims for admissions during each hospital's fiscal year ending during the second year of the base period.

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The invoice file is adjusted to:

- Eliminate episodes with any Medicare charges.
- Eliminate episodes without any charges or days.
- Limit episodes to those from Michigan hospitals (provided that hospital cost report data are available for a period ending in the second state fiscal year used for the base period, including hospitals that are not longer in operation).
- Limit episodes to those with a valid discharge status (incomplete episodes were excluded as are additional pages of a multiple page bills where there is no initial claim containing a valid discharge status).

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the cost to charge ratio for the hospital.

- Each hospital's operating cost to total charge ratio is obtained from filed cost reports for fiscal years ending in the second year of the base period. If the cost to charge ratio is greater than 1.00, then 1.00 is used. For distinct part psychiatric and rehabilitation units, this ratio is unique to the unit.
- If two or more hospitals merged and are now operating as a single hospital, a cost to charge ratio is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data will be inflated to a common point in time.

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital.

To determine a hospital specific Per Diem base rate:

- Multiply the cost per day by the applicable inflation factor. Each hospital's costs are inflated to a common point in time. Inflation factors were obtained from the 2nd Quarter 1999 Data Resources, Inc. PPS-Type Hospital Market Basket Index.

Per Diem Base FYE	Inflation to 96/97
9/30/96	1.021
12/31/96	1.017
3/31/97	1.012
6/30/97	1.008
8/30/97	1.000

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The inflation update for the quarter in which the hospital's fiscal year ends is used.

- Recognize hospital specific cost differences by dividing the cost per day for each hospital by a hospital specific cost adjustor factor. Each hospital's cost adjustor is calculated as follows:

  ➢ Cost Adjustor = 0.9 x Wage Adjustor + 0.1

  ➢ This formula is the algebraic derivation of:

  0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

  The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.

  ➢ Each hospital's wage factor is wage per full-time equivalent (F.T.E.) divided by the statewide average hospital wage per F.T.E. Contract labor costs are included in determining a hospital's wage costs.

  ➢ Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation factors. All wages are brought to a common point in time. The following adjustment factors, derived from the 2nd Quarter 1999 Data Resources, Inc. PPS-Type Hospital Market Basket Index, employee cost component, are used:

FYE	Per Diem Base Wage & Benefit Inflation to 96/97
9/30/96	1.030
12/31/96	1.026
3/31/97	1.018
6/30/97	1.010
8/30/97	1.000

  For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

  ➢ The wage data for distinct part psychiatric and rehabilitation units is the same as for the inpatient medical/surgical area of the hospital. The cost reports do not differentiate salaries/hours by unit type.

  ➢ If two or more hospitals merge and are now operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data will be inflated to a common point in time.

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- Remove indirect medical education (IME) costs by dividing by an adjustor for indirect education. Each hospital's IME adjustor is calculated as follows:

  - $IME\ Adjustor = 1 + 0.715 \times [(1 + Interns\ \&\ Residents/Beds)^{0.5795} - 1]$

  - Distinct part psychiatric and rehabilitation units report this data separately. The IME adjustor is unique to the unit.

  - If two or more hospitals merge and are now operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

To determine the per diem rate:

- Calculate the statewide operating cost limit (by provider type). This is a weighted mean of all hospitals' specific base prices weighted by base period days (truncated mean), multiplied by the appropriate percentage.

  - For freestanding psychiatric and rehabilitation hospitals the percentage is 150%.

  - For distinct part psychiatric units the percentage is 110% of the 50th percentile.

  - The 50th percentile is determined by calculating a standardized rate for each unit. The standardized rate for all enrolled Michigan units are sorted in ascending order. The standardized rate of the first unit after the 50% of the units listed becomes the statewide 50th percentile.

  - For distinct part rehabilitation units the percentage is 200%.

- Calculate the statewide operating cost minimum (by provider type). This is a truncated, weighted mean of all hospitals' specific base prices weighted by base period days multiplied by 70%.

- The per diem base rate is the lesser of:

  - The greater of the hospital specific base price or the statewide operating cost minimum, or

  - The statewide operating cost limit.

Adjust each hospital's per diem rate by the updated cost adjustor (to reflect a hospital specific per diem rate). The updated cost adjustor is calculated, to reflect the most current data available, in the same manner as the base cost adjustor, except that:

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- Medicare audited wage data for hospital fiscal years ending between September 1, 1996 and August 31, 1997 is used.

- The wage and benefit inflation factors are derived from the employee cost component of the Data Resources, Ind. PPS-Type Hospital Market Basket Index. The same inflation factors were used here as were used for the DRG update found in Section III, B., *DRG Price*.

- In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments are made either to the base or the update period to render the data comparable.

Calculate the final per diem rate by rounding to the nearest whole dollar.

2. Hospitals Outside of Michigan

Freestanding rehabilitation hospitals and distinct part rehabilitation units not located in Michigan are reimbursed using a per diem rate. The per diem rate is the statewide weighted average per diem (truncated mean) for this provider type.

3. New Freestanding Hospitals and Distinct Part Units

If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request in writing that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by MSA, whichever is later.

New freestanding hospitals and distinct part units are reimbursed using the statewide average (weighted by days during the base period) per diem rate for the provider type.

A hospital/unit specific per diem rate is established when new rates are calculated using data from time periods during which the new hospital/unit provided services to Medicaid patients.

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E. Frequency of Recalibration

The inflation factors listed below were used to equalize base prices and bring them to a common point in time – April 1, 2000. Inflation factors for the first three periods were obtained from the 1st Quarter 1998 Data Resources, Inc. PPS-Type Hospital Market Basket Index. For fiscal years 1998/99 and 1999/00, the department budget did not provide for inflation updates.

To 1995-96	1.025
To 1996-97	1.025
To 1997-98	1.027
To 1998-99	1.000
To 1999-00	1.000

- Relative weights are recalibrated annually.
- DRG prices will be rebased every three years and updated annually.
- Per Diem rates will be rebased every two years and updated annually.
- Inpatient operating cost to charge ratios are recalculated with each DRG/Per Diem rebasing.

F. Mergers

1. General Hospitals

In the event of a merger between two or more hospitals between DRG rebasing periods, the DRG rate for the surviving hospital will be computed as follows:

- Cost to charge ratio, indirect medical education (IME), and wage data will be inflated to a common point in time (for the surviving entity).
- No changes will be made to the relative weights.
- The DRG rate will be computed with the same methodology as described in the section covering the computation of the DRG rates, with the following exceptions:
  - ➢ No change will be made to the statewide operating cost limit.
  - ➢ No change will be made to the statewide average used to compute the update base wage adjustor.
  - ➢ No change will be made with respect to the statewide average used to compute the update wage adjustor.

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- As part of recalibration or rebasing, all data will be combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.

2. Freestanding Psychiatric and Rehabilitation Hospitals/Distinct Part Psychiatric and Rehabilitation Units

In the event of a merger between two or more hospitals between per diem rebasing periods, the resulting per diem rate for the surviving hospital will be computed as follows:

- Cost to charge ratio, indirect medical education (IME), and wage data will be inflated to a common point in time (for the surviving entity).
- The per diem rate will be computed using the same methodology as described in the section covering the computation of the DRG rates, with the following exceptions:
  - ➢ No change will be made to the statewide operating cost limit.
  - ➢ No change will be made to the statewide operating cost minimum.
  - ➢ No change will be made to the statewide average used to compute the base wage adjustor.
  - ➢ No change will be made to the statewide average used to compute the update wage adjustor.
- As part of recalibration or rebasing, all data will be combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.

G. Other Reimbursement Methods

1. Sub-Acute Ventilator-dependent Care

Reimbursement for services provided to patients in sub-acute ventilator-dependent care units is through a prospective per diem rate. The per diem rate covers the costs of capital and direct medical education, routine accommodations, regular ancillary services, and regular professional services.

The per diem rate is established using a variety of data including: cost report data (the sub-acute ventilator-dependent care unit must be treated as a separate distinct part), the rate of utilization in the unit, inflation, professional costs, the rates paid to ventilator-dependent units in long term care facilities, and the cost and availability of suitable alternative placements. Effective October 1, 1991, the per diem rate is set to not exceed the per diem rate that would be paid for outlier days under DRG 483 (Tracheostomy Except for Mouth or Pharynx Disorder).

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If a need for the services exists, the rate is specified in a contract offer from the Medicaid Program to the hospital.

2. Michigan State-Owned Hospitals

Reimbursement to Michigan state-owned hospitals is allowable costs under Medicare principles of reimbursement as freestanding psychiatric hospitals exempt from the prospective payment system.

H. Disproportionate Share

Minimum Eligibility Criteria
Indigent volume data is taken from each hospital's cost report and from supplemental forms that each hospital must file with its cost report. Data from the most recent available filed cost report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and applied to distinct part psychiatric units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for payments under the Medicaid, CSHCS and the State Medical Program plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

Each hospital must have Medicaid utilization rate of at least 1%. Medicaid utilization is measured as:

$$\frac{\textit{Medicaid Inpatient Days (Whole Hospital including Subproviders)}}{\textit{Total Hospital Days (Whole Hospital including Subproviders)}}$$

Individual inpatient hospital claims will be paid without DSH adjustments. Inpatient DSH payments will be made annually in a single distribution based on charges converted to cost using a cost to charge ratio. The payment will be made normally during the first quarter of the state fiscal year. Each hospital's indigent volume will be taken from hospital cost reporting periods ending during the second previous state fiscal year.

Title XIX charges used to compute DSH payments will be the sum of the Title XIX charges and the Title XIX HMO charges from hospital indigent volume reports for cost periods ending during the second previous state fiscal year. Data for cost periods of more or less than one year will be proportionally adjusted to one year.

Hospital operating cost ratios will be taken from hospital cost reporting periods ending during the second previous state fiscal year. For hospitals with more than one cost reporting period ending in this date range will have their data from the two periods added and a single ratio will be computed. If the ratio is greater than 1.0, a ratio of 1.0 will be used.

Reimbursement for inpatient services under Title V will not include DSH payments.

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In order to qualify for DSH payments, hospitals must have at least one percent Medicaid inpatient days to total inpatient days.

Hospitals that fail to supply indigent volume data will not be eligible to receive disproportionate share payments.

For new hospitals, disproportionate share payments will be withheld until the hospital's indigent volume can be calculated and applied in the normal update process.

For new distinct part psychiatric units of general hospitals, the indigent volume data from the general hospital will be used to determine DSH payments applicable to the distinct part psychiatric units until the unit's indigent volume can be calculated and applied in the normal update process.

To be eligible to receive DSH payments, hospitals must also meet at least one of the following criteria. Except for hospitals and distinct part psychiatric units eligible under the fourth criteria (➢) listed below, hospitals will be contacted annually by letter and asked to report their status on these criteria.

The hospital must:

- ➢ have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services; or
- ➢ be located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and have at least two (2) physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services; or
- ➢ serve as inpatients a population predominantly comprised of individuals under 18 years of age; or
- ➢ as of December 22, 1987, not have offered non-emergency obstetric services to the general population.

1. Inpatient Hospitals

State fiscal year 1997 disproportionate share hospital payments for services in all hospitals, except for state-owned mental hospitals, are fixed at $45 million. The pool allocations were determined as follows:

$$\frac{\Sigma \text{ DSH Shares for Group}}{\text{Total DSH Shares}} \times \$45 \text{ Million}$$

The determination of the share of the allocated DSH pool will be made using the DSH share. The payment will be made by:

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$$\frac{\textit{Hospital's DSH Share}}{\Sigma\ \textit{DSH Shares for the Group}} \times \textit{Allocated DSH Pool}$$

The individual pool amounts are listed below.

a. DRG Reimbursed Hospitals

The DSH payments for DRG reimbursed hospitals are split into two pools. The indigent volume is shown on hospital price sheets for rates effective October 1, 1992.

- Hospitals with at Least 50% IV

  The share of the DSH payment paid to hospitals with at least 50% indigent volume (IV) is approximately $7.3 million and is based on a DSH computed as:

  Title XIX Charges x Operating Ratio x (IV - 0.5)

- Hospitals with at Least 20% IV

  The share of the DSH payment paid to hospitals with at least 20% IV is approximately $30.2 and is based on the following DSH amount. This is in addition to the amount above:

  Title XIX Charges x Operating Ratio x (IV - 0.2)

b. Per Diem Reimbursed Hospitals
(Including TEFRA Option Rehab Hospitals)

Per diem reimbursed hospitals are allocated approximately $7 million for DSH payments. The per diem factor is set prospectively using current indigent volume survey data. The share of the DSH paid to hospitals with IV of at least 20% is based on a DSH share of:

Title XIX Charges x Operating Ratio x (IV - 0.2)